

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-033660

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

8291

FILED AUG 22 1963

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)

ST. LOUIS, MO.

Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Mo.

b. COUNTY

admission)

c. CITY
OR
TOWN

St. Louis

Inside Limits
Yes ☐ No ☐

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR
INSTITUTION

ST. LOUIS CITY HOSP. #1

Inside Limits
Yes ☐ No ☐

d. STREET
ADDRESS

5235 Cates Ave.

Reside on Farm
Yes ☐ No ☐

3. NAME OF DECEASED
(Type or print)

First

Middle

Last

BABY BOY

GILLESPIE

4. DATE
OF
DEATH

Month

Day

Year

8

9

63

5. SEX

MALE

6. COLOR OR RACE

NEGRO

7. Married ☐ Never Married ☒

Widowed ☐ Divorced ☐

8. DATE OF BIRTH

8/9/63

9. AGE (last birthday)

IF UNDER 1 YEAR

IF UNDER 24 HR

Months

Days

Hours

Min.

28

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country)

ST. LOUIS, MO.

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13a. FATHER'S NAME

13b. MOTHER'S MAIDEN NAME

WILLIE LOUISE GILLESPIE

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

ST. LOUIS CITY HOSP. #1

1515 LAFAYETTE

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Prematurity

INTERVAL BETWEEN
ONSET AND DEATH

Conditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.

DUE TO (b)

DUE TO (c)

776 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY
PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT

SUICIDE

HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF
INJURY

Hour
a.m.
p.m.

Month, Day, Year

20d. INJURY OCCURRED
WHILE AT WORK ☐
NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home,
farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from

8/9/63

to 8/9/63

and last saw her alive on 8/9/63

Death occurred at

9:35 AM

m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

Anne E. Barron, M.D.

22b. ADDRESS

1515 LAFAYETTE AVE.

22c. DATE SIGNED

8/9/63

23a. BURIAL, CREMATION,
REMOVAL (Specify)

23b. DATE

8-31-63

23c. NAME OF CEMETERY OR CREMATORY

Anatomical Board

23d. LOCATION (City, town, or county)

St. Louis, Mo.

24. FUNERAL DIRECTOR

ADDRESS

Ogden 4106 Manchester

25. DATE RECD. BY LOCAL REG.

AUG 15 1963

26. REGISTRAR'S SIGNATURE

Boad Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

BARRON
USE BLACK INK
OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body, whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a **STUDENT**, he also shall sign in his **OWN handwriting**.

If this body is not embalmed, fact should be so stated above.